SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1188

SPONSOR: Banking and Insurance Committee

SUBJECT: Insurance

DATE: April 24, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.			GO	
3.			AGG	
4.			AP	
5.				
6.				

I. Summary:

The committee substitute provides changes to the workers' compensation system that are designed to increase benefits, expedite the dispute resolution process, and reduce costs to the overall administration of the workers' compensation system. The following is a summary of the major changes by category:

Benefits

1. Removes the Social Security standard for eligibility for permanent total disability benefits from the definition of "catastrophic injury."
2. Revises eligibility for permanent total disability claims, in all cases other than catastrophic injuries, to provide that the injury eligible for permanent total disability must be of a nature and severity that prevents the employee from being able to perform his or her previous work. If the employee is engaged in or is capable of being engaged in any substantial gainful employment, he or she is not entitled to permanent total disability. The burden would be on the employee to establish that he or she is unable to perform work within a 50-mile radius of the employee's residence.
3. Allow employees to change doctors one time per accident, upon written request.
4. Increases permanent partial disability impairment income benefits from half the compensation rate to the full compensation rate (66 2/3 of the employee's average weekly wage).
5. Allows employers and carriers to deliver medical benefits either through a workers' compensation managed care arrangement or outside of a workers' compensation managed care arrangement.
6. Allows employers and carriers to negotiate medical fees in excess of the uniform reimbursement schedule and provides that the maximum reimbursement allowance for

inpatient and outpatient care cannot exceed the percentage increase in the Consumer Price Index for the prior year, except when the three-member panel adopts a nationally recognized reimbursement methodology.

7. Provides that family members who provide non-professional attendant care will be paid at the rate of their regular employment, not to exceed the value of that care in the community.
8. Requires the carrier to pay for the claimant's first independent medical examination per accident but permits each party to introduce the medical opinion of one independent medical examiner per specialty into evidence.
9. Prohibits the payment of impairment income benefits for preexisting mental, psychological, or emotional conditions.

Informal Dispute Resolution

1. Eliminates the request for assistance process.
2. Authorizes the Division to contact the injured worker or the workers' representative directly upon receipt of the notice of injury or death.
3. Requires that a request for medical care be filed before a "grievance" may be filed with a managed care arrangement and provide that the informal dispute resolution process is exhausted if the workers' compensation managed care arrangement does not respond to a grievance within 30 days of filing.

Formal Dispute Resolution

1. Authorizes the partial dismissal of petitions for benefits, without prejudice.
2. Replaces the "notice of denial" with a "response to petition" for purposes of granting or denying benefits requested by petition.
3. Revises the statutory dispute resolution time line.
4. Authorizes the judges of compensation claims to issue an abbreviated final order.
5. Authorizes the use of private mediation prior to the date of mandatory mediation.
6. Resolves medical-only claims less than $5,000 and medical mileage disputes through expedited dispute resolution.
7. Requires additional specificity for petitions for benefits and authorize the Deputy Chief Judge to require additional specificity in petitions by rule.
8. Requires judges of compensation claims to review all settlement proposals, stipulations, and agreements between the claimant and their attorney for compliance with the provisions concerning attorney's fees.
9. Requires the judges of compensation claims, when reviewing lump-sum settlement agreements, to consider whether the settlement provides for the appropriate recovery of any child-support arrearages and provides that neither the employer or carrier has a duty to investigate or collect information concerning child-support arrearages.
10. Prohibits the use of a mediation conference solely for the purpose of mediating attorney fees.
11. Provides that continuance orders for final hearings must set the rescheduled date by order and requires the judges of compensation claims to report to the Deputy Chief Judge the granting of two or more continuances to a requesting party and requires written consent

of the claimant prior to the judge of compensation claims granting an additional continuation after the initial continuation.

12. Increases the attorney's fee schedule to equal 25 percent on the first $5,000 benefits secured, 20 percent on the next $5,000 secured, 15 percent on the remaining amount of benefits secured during the first 10 years after the claim is filed, and 10 percent of the benefits secured after the first 10 years. The judge of compensation claims may approve an additional attorney's fee of up to $2,500, based on a reasonable hourly rate, if the judge of compensation claims expressly finds that the attorney's fees based on the benefits secured fails to fairly compensate the attorney. Such fees would be allowed for any petition for benefits that are ripe, due, and owing that should have been raised. Any attorney fees are waived on any other benefits which were not raised and which were ripe, due, and owing at the time the issues are resolved. The judge of compensation would be prohibited from awarding attorney fees that exceed the benefits secured.

Exemptions From Workers' Compensation Coverage

The committee substitute eliminates the exemptions from coverage for the businesses primarily engaged in the construction industry. According to study recently released by the University of Florida, it was estimated that $1.3 billion in workers' compensation premiums is lost, on annual basis, due to employer premium fraud and exemptions in the construction industry.

Non-construction industry sole proprietors, partners in a partnership, and officers in a corporation could continue to elect to be exempt from coverage. Individuals would be required to maintain certain documentation and produce such documentation upon request of the Division of Workers' Compensation to substantiate such exemptions.

Other Provisions

The committee substitute also requires the Department of Insurance to conduct a study and submit a report to the Legislature on the extent to which health insurance policies and health maintenance organization contracts currently cover workplace injuries that are not covered by workers' compensation policies and the costs attributable coverage and under such options as the department may consider.

The committee substitute also authorizes a public entity or agency to purchase a consolidated insurance program for the purpose of providing coverage for workers' compensation, employers' liability, general liability, builders' risk, or pollution liability to the public entity or agency or to a contractor or subcontractor for a public construction project.

In addition, the committee substitute repeals the Workers' Compensation Oversight Board.

This bill substantially amends the following sections of the Florida Statutes: 440.02, 440.05, 440.09, 440.10, 440.13, 440.134, 440.14, 440.15, 440.185, 440.191, 440.192, 440.20, 440.25, 440.29, 440.34, 440.345, 440.39, and 627.412. Section 440.4416 and subsection (3) of s. 440.45, F.S., are repealed.

II. Present Situation:

Pursuant to s. 440.015, F.S., the Division of Workers= Compensation, within the Department of Labor and Employment Security, is charged with administering the Workers= Compensation Law in a manner, which facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of payments. The legislation was intended to create "an efficient and self-executing system . . .which is not an economic or administrative burden."

In recent years, workers' compensation rates have remained relatively low or unchanged. For the period of 1994 - 2001, 3 years had no rate increase (1995, 1996, and 2001). In 1994, 1997, and 1998, the rates decreased -10.6, -11.3, and -2.1 percent, respectively. In 1999 and 2000, the rates slightly increased 1.5 and 2.5 percent, respectively. The National Council of Compensation Insurers provided committee staff with a comparison of the distribution of a benefit dollar in Florida, California, and Texas. The following table depicts the expenditures for medical versus indemnity benefits for every dollar in benefits in those three states:

	Medical Benefits	Indemnity Benefits
Florida	65.6%	34.4%
California	42.5%	57.5%
Texas	60.7%	39.3%

NCCI also provided information concerning the pure loss costs among 37 states. Loss costs are the projected benefit dollar that will be paid per $100 of payroll for the average insured in that classification for policies. In comparing loss costs among the state, many factors may impact the cost differences among state, including: benefit structure, administration of the workers' compensation system, number and types of risk exposures for workers, characteristics of the workforce, economic condition of a state, enforcement and use of safety programs, wages of workers, medical cost containment measures, and regulation by a state. Florida had the highest loss costs of the 37 states ranked by NCCI. Florida had a 2.75 loss costs, Montana was second with a 2.50 loss costs. The weighted average among the states was 1.61 percent. Texas and California were not included in the ranking.

The Division of Workers= Compensation and the Office of the Judges of Compensation Claims are primarily funded through assessments on insurance companies, self-insurance funds, assessable mutual companies, the Workers= Compensation Joint Underwriting Association, and self-insurers. The assessments are deposited into the Workers= Compensation Administrative Trust Fund. For FY 1999-2000, the assessment rate was 3.48 percent. For the period of July 1, 2000, through December 1, 2000, the assessment rate was 3.74 percent. For the period of January 1, 2001, through July 1, 2001, the assessment rate will be 2.75 percent, which is the statutory cap effective January 1, 2001.

Division of Workers' Compensation

Presently, the division is organized into the following program/function areas: Monitoring and Audit, Employee Assistance and Ombudsman Office, Rehabilitation and Medical Services, Operations Support (including the Special Disability Trust Fund), Compliance, Research and Education, Information Management, and the Director's Office.

The Bureau of Employee Assistance and Ombudsman Office (EAO) is charged with the responsibility of informing and assisting employers/carriers, injured workers, and health care providers in fulfilling their respective responsibilities under ch. 440, F.S., the Workers= Compensation Law. Section 440.191, F.S., also directs EAO to Atake all steps necessary to educate and disseminate information to employees and employers.@ To effect the self-executing features of the law, s. 440.191, F.S., provides that ch. 440, F.S., is construed to permit injured workers and employers/carriers to resolve disputes A. . . without undue expense, costly litigation, or delay in the provisions of benefits.@ As a result, EAO investigates disputes and attempts to resolve disputes between injured workers and the carrier/employer in an informal manner through the Request for Assistance process. Rules 38F- 26.002 and 26.004, F.A.C., require such a request to be submitted on a division Request for Assistance form.

According to the division, since 1994, the number of requests for assistance received on an annual basis has increased from 45,466 to more than 119,000, with over 95 percent of all requests for assistance being filed by attorneys. Over 82 percent of the disputed issues on the requests are either not due or owing, or are not within the jurisdiction of the EAO to resolve.

In 1999, EAO implemented a statewide program, known as the Early Intervention Program, which is aimed at notifying injured workers regarding their rights under the law soon after the division receives the notice of injury. An evaluation of preliminary data (as of July 1, 2000) indicates that EAO has experienced a 30 percent reduction in the rate of requests for assistance filed and a 33 percent reduction in the rate of petition for benefits submitted for workers injured in 1999 that have participated in the program.

An employee may not file a petition for benefits unless the employee has exhausted this informal dispute resolution process. If resolution is not made in 30 days, EAO may assist the employee in drafting a petition for benefits. Under the provisions of s. 440.192, F.S., the employee is required to serve the petition upon the employer, the employer's carrier, and the division. The division refers the petition to the Office of the Judges of Compensation Claims for ultimate disposition.

The Formal Dispute Resolution Process

The judges of compensation claims are responsible for hearing and resolving disputed workers' compensation issues under the authority of ch. 440, F.S. Under the provisions of s. 440.192, F.S., the employee is required to serve the petition upon the employer, the employer's carrier, and the division. Within 14 days of receipt of a petition for benefits, the carrier must either pay the requested benefits without prejudice to its right to deny within 120 days of receipt of the petition or file a notice of denial with the division. The carrier is then required to commence an investigation of the employee's entitlement to benefits under ch. 440, F.S., and must admit or deny compensability within the 120 days after the initial provision of benefits or compensation.

The division acts as the quasi-agency clerk and custodian of records for the Office of the Judges of Compensation Claims. Ten full-time positions are responsible for receiving the petitions, entering data, and generating the docketing order. After imaging or copying the petition, the division prepares a docketing order for each petition and refers the petition to the docketing

judge. Once the filed petitions for benefits are available online, the turnaround time should be reduced significantly.

Upon receipt of the petition for benefits, the judge is authorized to dismiss the petition if the petition does not specifically identify or itemize certain information required by the section, including information regarding the employee, employer, the injury, employee's work responsibilities, benefits being requested, type of care being requested, and any other disputed issues, as delineated in s. 440.192, F.S. Presently, the statute does not specifically authorize the judge to dismiss a portion of the petition. If the petition is not dismissed, it is referred to the appropriate district.

Section 440.25, F.S., requires a mediation conference to be held within 21 days after a petition for benefits is filed with the division. Only the Chief Judge is authorized to waive a mediation conference. Within 7 days after the petition filing, the judge of compensation claims is required to notify the parties that a mediation conference will be held. According to the Office of the Judges of Compensation Claims, for FY 1999-00, the average turnaround time from the receipt of the petition by the division and the scheduled mediation date was 145 days. If the issues have not been resolved within 10 days following the commencement of the mediation, the judge is required to hold a pretrial hearing.

The judge is required to provide the parties with at least 7 days advance notice of the pretrial hearing. At the pretrial hearing the judge sets a date for the final hearing that allows the parties at least 30 days to conduct discovery, unless the parties consent to an earlier hearing date. The final hearing is required to be held and concluded within 45 days after the pretrial. The judge is authorized to grant continuances, if the requesting party demonstrates that the reason for the delay arises from circumstances beyond the party's control. According to the Office of the Judges of Compensation Claims, 11,938 continuances for final hearings were issued for FY 1999-00. The judge is required to provide the parties with at least 7 days advance notice of the final hearing.

The judge is required to determine the dispute in a summary manner within 14 days after the final hearing. If the case is not determined within 14 days of the final hearing, the judge is required to formally notify the Chief Judge. According to the Office of the Judges of Compensation Claims, the average number of days from the date of receipt of the petition by the division to the final disposition (final merit, settlement, or stipulation) is 220 days.

Dispute Resolution Workload

During the preceding 2 years, the Division of Workers' Compensation received an average of 100,073 petitions per year. Of these petitions, an average of 91,296 (or 91 percent) were forwarded to the presiding judges during the same period. The Office of the Judges of Compensation Claims estimates that three petitions are filed per injury and will be ultimately consolidated into one petition. For the same period, an average of 3,277 final hearings were held, 2,622 final orders were issued, and 35,013 lump sum settlements were entered per year. An average of 19,701 mediations were also held per year. The average resolution rate for all issues, except for attorney fees, for concluded mediations, was 46.2 percent for the 2-year period.

Review of any order of a judge of compensation claims must be by appeal to the District Court of Appeal, First District. For 1999, the First District Court of Appeals disposed of 502 total cases, of which 274 were affirmed (54 percent), 54 reversed (11 percent) and 174 were disposed by administrative orders. The Clerk of the First District Court of Appeals reported that a total of 328 workers' compensation merit decisions were issued in 1999 of which 54 cases (16 percent) were reversed and 274 (84 percent) were affirmed. Two cases listed as unknown were nondispositive orders that did not finalize the case.

In October of 2000, the staff of the Committee on Banking and Insurance released a report, entitled "*An Evaluation of the Transfer of the Workers' Compensation Hearings from the Department of Labor and Employment Security to the Division of Administrative Hearings*." This report evaluated the administration of the Office of the Judges of Compensation Claims and the feasibility of transferring the judges of compensation claims to the Division of Administration. The current statutory time frames and the actual time frames for the formal dispute resolution process were evaluated. Staff noted that the judges of compensation were generally unable to meet the current statutory timeframes relating to the formal dispute resolution process. Recently, staff conducted a follow-up on the average, actual time frames required by the judges of compensation claims to resolve disputes. The following is a summary of the actual time frames and the statutory time frames:

1. Dispute resolution process took an average of 221-234 days. The statutes require 120 days for resolution.
2. The presiding judges of compensation claims receive the petitions for benefits until 45 days after the petition was filed. Mediation conferences are required to be held within 21 days of the receipt of the petition. Presently, the docketing judge does not receive the petition until 14-30 days after receipt by the Division of Workers' Compensation. The presiding judge receives the petition, on average, 6-15 days later.
3. Mediation occurs, on average, 104-120 days after the filing of the petition for benefits.
4. On average, the pretrial hearing occurred 30 days after mediation. The statute requires the pretrial to occur within 10 days of the mediation conference.
5. Approximately 45 days elapsed between the pretrial hearing and the final hearing. The statute requires the final hearing to occur within 45 days of the pretrial hearing.
6. On average, 25 days elapsed between the final hearing and the issuance of the final order or the determination in a summary manner. The statute requires a determination in a summary manner within 14 days of the final hearing.

Indemnity Benefits

Permanent total disability is determined at maximum medical improvement, based upon reasonable medical probability that no further medical improvement can reasonably be anticipated. It is a lifetime benefit calculated at 66 2/3 of the average weekly wage. In addition, a person will receive supplemental income benefits of 5 percent per year. The permanent total benefits cannot exceed the maximum compensation rate. According to the NCCI Annual Statistical Bulletin, 2000 Edition, Florida, at 20.2 percent, has one of the highest incurred losses in the permanent total disability category for 45 states reviewed. Only Colorado has a higher incurred loss in the permanent total disability category, at 20.9 percent. California and Texas reported 6.4 and 8.1 percent, respectively.

Impairment income benefits occur at maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier and continues until the earlier of the expiration of a period computed at a rate of 3 percent for each percentage point of impairment or the death of the employee. It is based on a physician's objective findings and is paid at 50 percent of the compensation rate.

Workers' Compensation Managed Care

As a result of the 1993 reforms, workers= compensation managed care was authorized (on a voluntary basis) on January 1, 1994, and mandated, effective January 1, 1997. Section 440.13(11), F.S., authorizes the division to determine A. . . whether providers are complying with ch. 440, F.S., and with rules adopted by the division, whether the providers are engaging in over utilization, and whether providers are engaging in improper billing practices.@ Specifically, the division is provided with A. . . exclusive jurisdiction to decide any over utilization dispute under s. 440.13(7), F.S., and to decide any question concerning over utilization under subsection (8), which question or dispute arises after January 1, 1994.@ The division is also directed to monitor and audit carriers to determine if medical bills are being paid in accordance with s. 440.13, F.S., and rules promulgated by the division. Section 440.13, F.S. also requires health care providers are required to furnish medical records and discuss relevant medical facts with the employer, the carrier, or the attorney for either party. Rehabilitation providers are not expressly authorized as having this ability.

The Agency for Health Care Administration is responsible for authorizing carriers to offer or utilize a worker's compensation managed care arrangement, if the carrier meets the conditions of s. 440.134, F.S., and regulating workers' compensation managed care arrangements. Managed care arrangements are required to resolve the grievance in a Atimely manner.@ Rules promulgated by the Agency for Health Care Administration require a determination of a grievance within 60 calendar days after receipt. Presently, the Division of Workers' Compensation has 30 days to resolve disputes. This timing difference may cause problems coordinating the resolution of medical and indemnity issues.

Election of Exemption from Workers' Compensation Coverage

Under the provisions of s. 440.38, F.S., employers are required to provide workers= compensation, unless they obtain an exemption from coverage. Employers secure workers= compensation coverage by purchasing insurance or meeting the requirements to self-insure.

Generally, coverage is required for employers with four or more employees. Sole proprietors and partners are automatically exempt from coverage requirements, but may elect to be covered. Officers of corporations are automatically covered, but may elect to be exempt from coverage. There is no limit on the number of corporate officers from a single non-construction industry business that can be exempt at any one time.

In the construction industry, coverage is required if a sole proprietor has one or more employees. No more than three partners or three officers of a corporation that is actively engaged in the construction industry may elect to be exempt from coverage.

Corporate officers, partners, and sole proprietors actively engaged in the construction industry may elect to be exempt from the workers= compensation system by filing a notice of election to be exempt and providing certain information to the Division of Workers= Compensation along with a $50 filing fee. For each employer seeking an exemption, the division requires the following information to be submitted: (1) listing of the names of the individuals seeking an exemption, (2) federal identification number, (3) social security number, (4) all certified or registered licenses issued pursuant to ch. 489, F.S., held by the person(s) seeking the exemption, (5) a copy of relevant documentation as to employment status filed with the Internal Revenue Service as specified by the division, (6) a copy of the relevant occupational license in the primary jurisdiction of the business, and (7) for corporate officers and partners, the registration number of the corporation or partnership filed with the Division of Corporations of the Department of State. The construction industry certificate of election of exemption is valid for 2 years.

Upon determining that the requirements for exemption are met, the Division of Workers= Compensation issues a certificate of election of exemption, which is valid for a 2-year period. However, the Division of Workers= Compensation has the authority to revoke the exemption if the person does not meet the requirements for an exemption or if the information is invalid.

In 1999, Florida had an estimated written workers' compensation premium of $2.5 billion. In addition, an estimated $1.0 billion in uncollected premium was attributed to the fraudulent use of exemptions from coverage in the construction industry.

The Task Force on Workers' Compensation Administration

During the 2000 Session, the Legislature enacted legislation creating the Task Force on Workers' Compensation Administration "for the purpose of examining the way in which the workers' compensation system is funded and administered." The Legislature directed the task force to submit recommendations concerning the source of system funding, the cost-effective use of funds, services and functions meriting funding, services and functions housed within the Division of Workers' Compensation, potential cost savings in system administration, and organizational changes to make the administration of the system more efficient. The task force provided many recommendations, including the following major recommendations:

1. Continue to fund the system through assessments on premium.
2. Eliminate the Workers' Compensation Oversight Board.
3. Transfer the Division to the Department of Insurance.
4. Transfer the judges of compensation claims to the Division of Administrative Hearings within the Department of Management Services.
5. Eliminate construction exemptions and require all persons in the construction industry to be covered by workers' compensation insurance.
6. Eliminate the request for assistance.
7. Repeal mandatory managed care.
8. Allow only one independent medical exam per accident.
9. Eliminate the judge of compensation claims' discretion to award attorney's fees that exceed the statutory contingency fee schedule.

10. Prohibit attorney's fees for average weekly wage and medical mileage disputes.
11. Require documentation to be submitted with petitions.
12. Eliminate the judges of compensation claims' jurisdiction over medical bill disputes.

Consolidated Insurance Programs

On May 26, 1993, the Attorney General opined (AGO 93-34) that the School Board of Dade County was not authorized to purchase insurance for or indemnify school board contractors or subcontractors who work on capital construction projects of the board. Presently, school districts, as well as other local governmental entities, are authorized to provide insurance for officers and employees of the district and their dependents. The attorney general stated that the "…mere fact of contracting with a school board to undertake capital construction projects would not appear to qualify either contractors or their subcontractors as officers or employees of the school district." Therefore, the school district "…would appear to be precluded from extending insurance benefits to contractors or subcontractors who work on capital construction projects for the district."

III. Effect of Proposed Changes:

Section 1. Amends s. 440.02, F.S., to revise definitions for catastrophic injury and terms related to the construction industry.

The term, "construction" would be revised to not include a homeowner's act of construction on such premises, if the premises were not intended to be leased within 1 year after the commencement of the construction.

The Division of Workers' Compensation would be authorized to establish by rule standard industrial classifications and their definitions, which meet the criteria of the term, "construction industry."

The definition of the term, "employee" is revised to mean any person who receives remuneration from an employer for the performance of any work or service or the provision of any goods or supplies.

Employee is defined to include all persons who are being paid by a general contractor for work performed by or as a subcontractor or employee of a subcontractor are employees of the general contractor, with exceptions. If a person meets the following eight criteria, such a person would not be deemed an employee:

1. maintains a separate business;
2. has a social security number or federal identification number;
3. controls the means of performing the services;
4. incurs the principal expenses related to the work performed;
5. responsible for the completion of work and services that is being performed;
6. receives compensation for work performed for a commission or on a per-job or competitive basis and not on any other basis, such as salary or wages;
7. may realize a profit or suffer a loss in connection with performing work or services; and

8. has continuing or recurring business liabilities or obligations.

A landowner would not be considered the employer of any person hired by the landowner to carry out construction upon his or her premises, if those premises are not intended for immediate sale or resale.

The definition of catastrophic injury is revised to mean only permanent impairment constituted by certain specified incapacitating injuries delineated in the subsection. The subsection would eliminate the provision that allowed any other injury that would otherwise qualify an employee to receive disability income benefits under Title XVI of the Federal Social Security Act to be considered a catastrophic injury.

Section 2. Amends s. 440.05, F.S., relating to election of exemption from coverage, to substantially reword the section. Sole proprietors, partners, and corporate officers not primarily engaged to be in the construction industry would be considered exempt from coverage, unless they elect otherwise. Presently, these sole proprietors and partners are exempt automatically from coverage and officers of corporations are automatically covered, but may elect to be exempt from coverage. Every enterprise conducting business in the state would be required to maintain certain business records and any corporation with exempt officers and any partnership with exempt partners would be required to maintain written statements of those exempted persons affirmatively acknowledging each such individual's exempt status.

A sole proprietor or partner claiming an exemption would be required to maintain federal tax returns for each of the immediately preceding 3 years. Any corporate officer claiming an exemption would be required to be listed on the records of the Division of Corporations within the Department of State. The corporate officer provides notarized documentation relating to the exemption and the individual's status as a corporate officer.

The division would be authorized to issue a stop-work order to any sole proprietor, partner, or officer that failed or refused to provide information required by the division to document the exemption.

Sole proprietors, partners, and corporate officers primarily engaged in the construction industry would not be eligible for exemptions from coverage.

Section 3. Amends s. 440.06, F.S., to provide that if an employer that does not obtain coverage as provided in s. 440.10, F.S., by failing to meet the requirements in s. 440.38, F.S., would not, in any suit brought by an employee subject to this chapter to recover damages for injury or death be able to defend such a suit on the grounds that the injury was caused by the negligence of a fellow employee, or the injury was due to the comparative negligence of the employee.

Section 4. Amends s. 440.09, F.S., to require an employer to provide compensation or furnish benefits, if an employee suffers an accidental compensable injury or death arising out of work performed in the course and scope of employment.

Section 5. Amends s. 440.10, F.S., relating to liability for compensation to eliminate references to requirements relating to exemptions for the construction industry. A contractor would require a subcontractor to provide proof of workers' compensation insurance. Currently, a subcontractor is required to provide proof of coverage or copy of the certificate of election to the contractor.

The section would also be revised to eliminate exemptions for the construction industry.

Section 6. Amends s. 440.107, F.S., to authorize the division to issue a stop-work order on an employer, if the division determines that the employer has misrepresented to a carrier the size or classification of the employer's payroll.

Section 7. Amends s. 440.13, F.S., to provide limitations on the value of attendant care provided to an injured employee by a family member that remains employed while providing such care. The per-hour value of that care would equal the per-hour value of the family member's employment, not to exceed the per-hour value of such care available in the community at large. Presently, the section provides per-hour value of such care provided by a family member that leaves employment and a family member that is not employed.

The section also provides that a carrier would also be required to provide an employee, upon the written request of the employee, the opportunity for one change of physician during the course of treatment for any one accident. The employee could select another physician from among not fewer than three carrier-authorized physicians not professionally affiliated.

A carrier would also be required to pay the cost of one independent medical examination per accident, upon the written request of the employee. The costs of any additional independent medical examiners would be incurred by the party requesting the independent medical examination. The costs of independent medical examinations expressly relied upon by the judge of compensation claims to award benefits in the final compensation order would be taxable costs under s. 440.349(3), F.S. The employee and carrier are both authorized to submit into evidence, and the judge of compensation claims shall admit, the medical opinion of no more than one independent medical examiner per specialty.

Fees charged for remedial treatment, care, and attendance would be allowed to exceed the fee schedule, if provided by a contract entered into between an employer or carrier and a certified health care provider or facility for the payment of medical services for covered expenses. The section also provides that the maximum reimbursement allowance for inpatient and outpatient care cannot exceed the percentage increase in the Consumers Price Index for the prior year, except when the three-member panel adopts a nationally recognized reimbursement methodology.

Section 8. Amends s. 440.134, F.S., relating to managed care arrangements, to revise the grievance procedures and to eliminate mandatory managed care for the provision of medical treatment of injured employees.

The term, "grievance" is defined to mean a direct written complaint filed by an injured worker expressing dissatisfaction with the insurer's managed care arrangement's refusal to provide

medical care. Under the revised grievance procedures, within 15 days of receipt by the insurer or the insurer's managed care arrangement, whichever, is earlier, the insurer would be required to grant or deny a request for medical care. If the insurer denies the request, the insurer would be required to notify the injured worker in writing of his or her right to file a grievance.

If an insurer or the insurer's managed care arrangement fails to notify the injured worker of the outcome of the grievance in writing within 15 days from the date of the receipt of the grievance, the grievance would be presumed resolved against the injured worker and the grievance procedure would be considered exhausted for purposes of s. 440.192, F.S.

Section 9. Amends s. 440.14, F.S., to revise the calculation of injured worker's pay for the preceding 13 weeks immediately preceding the injury for purposes of determining the average weekly wage. The 13 weeks would be defined as the 13 complete weeks before the date of the accident, excluding the week the injury occurs. Presently, the 13 weeks is defined to mean substantially the whole of 13 weeks immediately preceding the injury. The term, "substantially the whole of 13 weeks," is defined to mean a consecutive period of 91 days.

Section 10. Amends s. 440.15, F.S., to revise the definition of permanent total disability and the definition of permanent impairment benefits. "Permanent total disability" is defined to mean any compensable injury eligible for permanent total disability must be of a nature and severity that prevents the employee from being able to perform his or her previous work. If the employee is engaged in or is capable of being engaged in any substantial, gainful employment, he or she is not entitled to permanent total disability. The burden would be on the employee to establish that he or she is unable to perform work within a 50-mile radius of the employee's residence. A catastrophic injury, in the absence of conclusive proof of a substantial earning capacity, would continue to constitute a permanent total disability.

Entitlement to permanent total disability supplemental benefits would cease at age 62 if an employee is eligible for social security benefits under 42 U.S.C. ss. 402 (early disability) or 423 (regular retirement). Presently, if a injured worker reaches permanent total disability after age 62, the injured worker is entitled to supplemental benefits after the age of 65.

Permanent impairment benefits would be doubled by requiring the payment at a rate equal to the employee's compensation (66 2/3 average weekly wage), rather than the current 50 percent of the employee's average weekly temporary total disability, which is approximately 33 percent of the average weekly wages. Permanent impairment compensation would not be payable for a preexisting mental, psychological, or emotional condition.

Section 11. Amends s. 440.185, F.S., to revise the notice of injury reporting requirements. In addition to the current information an employer must report to its carrier and to the employee or the employee's estate, the employer must also provide a record of the employee's earnings for the 13 weeks before the date of injury and other information the division would require by rule.

Section 12. Amends s. 440.191, F.S., relating to the informal dispute resolution, to revise resolution procedures and broaden the scope of individuals or entities the Employee Assistance Office assists or informs to include managed care arrangements.

The Employee Assistance Office (EAO) would be authorized to contact an injured worker or the injured worker's representative upon receiving a notice of injury or death to discuss rights and responsibilities of the employee under ch. 440, F.S., and the services available through EAO. This provision would codify the division's early intervention program. The specific duties and responsibilities of EAO relating to dispute resolution would be eliminated.

An injured worker would no longer be required to exhaust the procedures for informal dispute resolution as a prerequisite to filing a petition for benefits. An employee would no longer be required to contact the EAO to request assistance in resolving disputes. The 30-day period for resolving a dispute, prior to filing a petition, is eliminated.

Section 13. Amends s. 440.192, F.S., to revise procedures relating to the formal dispute resolution. An employee would be required to file by certified mail, or by electronic means approved by the Deputy Chief Judge, of the Office of the Judges of Compensation Claims, the petition that meets the requirements of this section. The employee would also be required to file copies of the petition with the employer and the employer's carrier. The employee would no longer be required to file a petition with the division.

The Deputy Chief Judge would refer the petition to the judges of compensation claims. Upon receipt of the petition, the Office of the Judges of Compensation Claims would review the petition and would be authorized to dismiss the petition or portions of the petition. Presently, the portions of a petition may not be dismissed. The dismissal of any petition or portion of the petition under this section would be without prejudice and would not require a hearing.

The section would also require the reporting of additional information on the petition for benefits, including the date or dates of the accident, the specific classification of the compensation not provided, specific travel costs an employee believes he or she is entitled, and a copy of the physician's request, authorization, or recommendation for treatment, care, or attendant care (if the employee is under the care of a physician). The Deputy Chief Judge would also be authorized to require additional information prescribed by rule.

Within 30 days, rather than 14, after receipt of the mediation, the carrier would be required to pay the requested benefits without prejudice to its right to deny within 120 days from receipt of the petition or file a response to the petition with the Office of the Judges of Compensation Claims.

Section 13. Amends s. 440.20, F.S., relating to payment of compensation, to allow eliminating mandatory hearings for lump-sum agreements, if the claimant is represented by counsel. Such a settlement agreement would require approval by the judge of compensation claims only as to the attorney fees paid to the claimant's attorney by the claimant.

Neither the employer nor the carrier would be responsible for any attorney's fees relating to the settlement and release of claims under this section. The judge of compensation could not approve any settlement proposals, including any stipulations or agreements between the parties or between the claimant and his or her attorney, which provide for an attorney's fee in excess of the amount permitted in s. 440.34, F.S.

Payment for the lump-sum settlement agreement would be required to be made within 14 days after the date the judge of compensation claims mails the order approving the attorney's fees. Any such order would not be considered an award and would be subject to review or modification.

The judge of compensation claims would be required to consider whether any lump-sum agreement under this section provides for appropriate recovery of any child-support arrearages. Neither the employer nor carrier would have a duty to investigate or collect information regarding child-support arrearages.

Section 15. Amends s. 440.25, F.S., to revise procedures for mediation and hearings. A mediation conference would be required to be held within 90 days, rather 21 days, within the receipt of the petition. Within 40 days of the receipt of the petition, rather 7 days after the receipt of the petition by the judge of compensation claims, the judge of compensation claims would be required to notify the parties, by order, of the date and time for the scheduled mediation. Continuances would be granted only if the requesting party was able to demonstrate to the judge of compensation claims that the reason for the request for continuance was due to circumstances beyond the party's control. Any order granting a continuance would be required to set forth the date of the rescheduled mediation. A mediation conference could not be used solely for the purpose of mediating attorney fees.

Unless the parties conduct a private mediation, the mediation would be conducted by a public mediator selected by the Deputy Chief Judge. In the event the parties agree to use a private mediator or no public mediator is available to conduct the mediation within the period specified in this section, the parties would be required to hold a mediation conference at the carrier's expense within the 90-day period for mediation. A private mediator would be required to be a member in good standing with the Florida Bar with at least 5 years' of Florida practice and certified under s. 44.16, F.S. If the parties could not agree upon a mediator within 10 days after the order, the claimant would be required to notify the judge in writing and the judge would be required to appoint a private mediator within 7 days.

If the claims, except for attorney's fees and costs, were not resolved at the mediation conference, the parties would be required make a good-faith effort to complete the pretrial stipulation before the conclusion of the mediation conference. The judge of compensation claims would be authorized to sanction a party or both parties for failure to complete the pretrial stipulation before the conclusion of the mediation conference.

In the event the parties failed to submit a pretrial stipulation at the mediation conference, the judge of compensation claims would be required to order a pretrial hearing to occur within 14 days after the date the mediation was ordered by the judge of compensation claims. Presently, if the issues are not resolved within 10 days following the commencement of the mediation, the judge of compensation claims is required to hold a pretrial hearing.

The final hearing would be required to be held and concluded within 90 days after the mediation conference, rather than 45 days after the pretrial hearing. Continuances would only be granted if the requesting party could demonstrate to the judge of compensation claims that the reason for the continuance arises from circumstances beyond the party's control. The written consent of the

claimant would be required before any request for additional continuance after the initial continuance would be granted. If a judge of compensation claims grants two or more continuances to a requesting party, the judge of compensation claims would be required to report such continuances to the Deputy Chief Judge.

The final hearing would be required to be held within 210 days after the receipt of the petition for benefits. Within 30 days of the final hearing or the closure of the hearing record, the judge of compensation claims would be required to enter a final order on the merits of the disputed issues. Presently, the judges of compensation claims are required to determine the dispute in a summary manner within 14 days of the hearing.

The judges of compensation claims would be authorized to enter an abbreviated final order in cases where compensability is not disputed. Either party would be allowed to request separate findings of fact and conclusions of law.

Unless the judge of compensation claims orders a hearing, claims related to the determination of pay would be resolved by the resolution of appropriate motions by judges of compensation claims without oral hearing upon submission of brief written statements in support and opposition, and for expedited discovery and docketing.

Claims for medical-only benefits of $5,000 or less or medical mileage reimbursement would be required to be resolved through the expedited resolution process, in the absence of compelling evidence to the contrary.

A judge of compensation claims would be authorized to dismiss a petition for lack of prosecution if no petitions, responses, motions, orders, requests for hearings, or notices of depositions have been filed for a period of 12 months, unless good cause is shown. Such dismissals would be without prejudice and would not require a hearing.

A judge of compensation claims would not be allowed to award interest on unpaid medical bills, nor use the amount of such bills to calculate the amount of interest awarded.

Attorney fees would not attach under subsection (4) until 30 days from the date the carrier, employer, if self-insured receives the petition, regardless of the date benefits were initially requested.

Section 16. Amends s. 440.29, F.S., to require that all medical reports of independent medical examiners whose medical opinion is submitted under 440.13(5), F.S., relating to the claimant would be received into evidence by the judge of compensation claims upon proper motion. Presently, the section authorizes the medical reports of authorizing treating health care providers to be received into evidence.

Section 17. Amends s. 440.34, F.S., to revise attorney fees. The fee schedule is increased to authorize a judge of compensation claims to approve an attorney's fee equal to 25 percent on the first $5,000 benefits secured, 20 percent on the next $5,000 secured, 15 percent on the remaining amount of benefits secured during the first 10 years after the claim is filed, and 10 percent of the benefits secured after 10 years. Currently, the judges of compensation may approve 20, 15, and

10 percent, respectively on benefits secured. In addition, the amount the judge may approve on benefits secured after 10 years is increased from 5 percent to 10 percent.

The judge of compensation claims may approve an additional attorney's fee of up to $2,500, based on a reasonable hourly rate, if the judge of compensation claims expressly finds that the attorney's fees based on the benefits secured fails to fairly compensate the attorney. Such fees would be allowed for any petition for benefits that would be ripe, due, and owing and that should have been raised in such a petition. Any attorney fees would be waived on any other benefits which were not raised and which were ripe, due, and owing at the time the issues are resolved.

The judge of compensation would also be prohibited from approving a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between claimant and his or her attorney, or any other agreement related to benefits which would provide for attorney's fees in excess of the amount permitted in this section. Presently, the judge of compensation claims may reduce or increase attorney fees, without limitation, based on certain factors delineated in subsection (1).

The section also provides that, regardless of the date benefits were initially requested, attorney fees would not attach until 30 days from the date the carrier or employer, if self-insured, receives the petition and denies the benefits.

Section 18. Amends s. 440.345, F.S., transfers the reporting of attorney's fees from the division to the Office of the Judges of Compensation Claims and requires the report to be submitted to President of the Senate, Speaker of the House of Representatives, and the Governor. Presently, the report is submitted to the Workers' Compensation Oversight Board.

Section 19. Amends s. 440.39, F.S., to revise the provisions regarding third-party liability, to provide that this section does not impose on the carrier a duty to preserve evidence pertaining to the industrial accident or to injuries arising.

Section 20. Amends s. 627.412, F.S., to authorize a public entity or agency to purchase a consolidated insurance program for the purpose of providing coverage for workers' compensation, employers' liability, general liability, builders' risk, or pollution liability to the public entity or agency, or to a contractor or subcontractor, for a public construction project.

Section 21. Requires the Department of Insurance to conduct a study and submit a report to the Legislature on the extent to which health insurance policies and HMO contracts currently cover workplace injuries that are not covered by workers' compensation policies and the costs attributable coverage and under such options as the department may consider.

Section 22. Repeals s. 440.4416, F.S., relating to the Workers' Compensation Oversight Board and subsection (3) of s. 440.45, F.S., relating to docketing by the judges of compensation claims, since the procedure would be eliminated by the bill.

Section 23. Provides severability clause for the bill. If any provision of this act or its application is held invalid, the invalidity would not affect other provisions or applications of the act and the provisions of the act are severable.

Section 24. Provides that this act would take effect January 1, 2002.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Based on the number of persons presently holding construction industry exemptions, it is estimated that approximately 100,000 persons presently holding exemptions (2 year exemption) would have to obtain coverage, if these exemptions were eliminated. The Division of Workers' Compensation provided the following information regarding the number of construction industry exemptions issued for the last 3 fiscal years:

	January 1 - June 99	July 99-June 2000	July 2000-March 01
Exemptions Issued	36,285	71,688	37,199

Estimated Impact on Rates

The National Council on Compensation Insurers estimated that the provisions of CS/SB 1188 would impact workers' compensation rates in the range of +2.7% to +4.3%. The following estimates concerning specific cost drivers were provided by NCCI.

Elimination of Exemptions for Businesses Primarily Engaged in Construction
NCCI has indicated that this provision would not have any present, measurable impact on workers' compensation system costs. NCCI does not expect the loss experience for these types of employers to be significantly different than average. It has been suggested that the elimination of this type of exemption would mandate coverage for employers whose losses may be currently entering the system in some cases. To the extent that this would produce additional premium, the effect will express itself over time through reported statistical experience.

Permanent Total Disability

According to NCCI the permanent total (PT) disability frequency is likely to drop significantly if the social security language is deleted from the definition of "catastrophic injury." Assuming that 70% of PT cases will become major permanent partial, the PT costs will decrease by 70% and the Major PP costs will increase by about 20%. The estimated impact on total indemnity costs is -4.5%. Since indemnity costs represent 40.2% of total benefits, the overall impact is -4.5% x 40.2% = -1.8%.

However, a few of the cases that currently qualify under social security provision, may also qualify under the proposed provision, as amended in s. 440.15(1)(b), F.S. If it is assumed that 60 percent of the permanent total cases would become major permanent partial, the overall impact is -1.5%.

Entitlement to Permanent Total Supplemental Benefits

The committee substitute provides that entitlement to permanent total supplemental benefits would cease if an employee is eligible for social security benefits under 42 U.S.C. section 401 or section 423. This provision, according to NCCI, may produce loss costs savings around 1 percent.

Permanent Partial Impairment Benefits

The permanent partial (PP) disability impairment benefits would be increased from 50% of the average temporary total (TT) disability benefit rate to 66 2/3% of the average weekly wage, not to exceed the maximum weekly benefit. According to NCCI, this proposal would effectively double impairment payments (since currently temporary total is paid at 66 2/3% and PP is paid at 50% of that amount). Impairment benefits represent approximately 30% of PP indemnity costs (with healing period, supplemental and rehabilitation benefits making up the rest). The impact on PP indemnity costs is thus: +100% x 30% = +30%. Since PP indemnity costs represent 21.6% of total benefits, the overall impact is +30% x 21.6% = +6.5%.

Medical Issues

According to NCCI, the elimination of mandatory managed care may reduce administrative costs however, this could be offset by increased costs over time due to higher medical costs experienced outside of managed care. NCCI also estimated that allowing injured workers to change physicians one time during the course of treatment for one accident would have a negligible impact on the overall system costs since the vast majority of medical benefits are delivered through managed care arrangements presently and the injured worker already permitted one change in physician.

Dispute Resolution

NCCI noted that several changes in the dispute resolution process would be expected to reduce attorney involvement and litigation rates, such as limiting continuances, requiring the use of the expedited hearing process in certain instances, and allowing for the partial dismissal of petitions.

Procedural Changes

NCCI indicated that it was difficult to quantify these changes, it is expected that these changes would be expected to reduce attorney involvement and litigation rates. The selected combined overall impact on rates is a range of -0.5% to 0%, relating to the following provisions: 1) requiring the carrier to pay for one independent medical examination; 2) not requiring contracts for medical treatment for covered expenses to be in accordance with the fee schedule; 3) authorizing the Employee Assistance Office to initiate contact with an injured worker to discuss the employee's rights and responsibilities and services offered by the office, and 4) requiring carriers to deny a request for medical services within 15 days and requiring written notification of the outcome of a medical grievance within 15 days.

Attorney Fees

The committee substitute would increase fees under the schedule by approximately 25%. Since claimant attorney fees now comprise about 1.5% of benefit costs, the fee schedule change would directly increase system costs by 0.4%. However, current practice suggests that claimants' attorneys are paid according to hourly rates rather than the statutory fee schedule. Since the hourly rate option is restricted, this would mitigate the increase and most likely result in some savings.

Besides a reduction in attorneys' fees, this proposal would also be expected to reduce the use of attorneys, as was the intent of the original law change. Since the presence of attorneys is correlated with higher benefit costs, this proposal would be expected to generate savings in these costs as well.

According to NCCI, by requiring attorney fees to attach 30 days after the carrier receives the petition, rather than 44 days after filing the petition, carriers may be able to resolve more disputes before the carrier becomes liable for the payment of attorney fees. This change should help reduce attorney involvement and costs.

C. Government Sector Impact:

According to the Division of Workers' Compensation, the elimination of the construction industry exemption fees ($50 per exemption) would have a significant impact on the division, based on the following exemption fee revenues generated since January 1999: $1.9 million for the period of January 1999-June 1999, $4.0 million; for July 1, 1999 through June 2000, $2.3 million for the period of July 1, 2001 through March 2001. These revenues are used to fund positions to administer the exemption process.

If exemptions for businesses primarily engaged in the construction industry are eliminated, additional staffing would be required to ensure that all sole proprietors, partnerships, and corporations that are primarily engaged in construction obtain and maintain the required coverage.

Procedural changes relating to the informal dispute resolution process and the formal dispute resolution should expedite the resolution process, thereby reducing overall costs to the workers' compensation system, possibly including assessments on carriers and employers for the administration of the Workers' Compensation Administration Trust Fund.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.